Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS19ADA	A. BUILDING _____ B. WING _____	C 10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCARE NEVADA, INC. - HARRIS SPRINGS RANC	**MAILING-5659 DUNCAN DRIVE LAS VEGAS, NV 89130**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comment The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. This Statement of Deficiencies was generated as a result of the Complaint Investigation conducted at your facility on 10/6/08 and completed on 10/9/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for fifty-six residential program beds for the treatment of abuse of alcohol and drugs. The census at the time of the survey was thirty-eight. Complaint #NV00019284 was substantiated. See Tag D075.	D 000		
D 075 SS=H	NAC 449.114(1) Employees 1. A facility must have on duty, all hours of each day, members of the staff sufficient in number and qualifications to carry out policies, responsibilities and program continuity. This Regulation is not met as evidenced by: Based on observations, interviews and record review from 10/6/08 to 10/9/08, the facility did not provide adequate staff supervision for 4 of 10 teen residents which resulted in a tattooing incident. Findings include:	D 075		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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D 075	Continued From page 1 The youth cabin was toured at 11:00AM. The cabin consisted of four resident bedrooms adjacent to a common room. The four bedrooms did not have bedroom doors separating the bedrooms from the common area. The common area contained a variety of furniture including a large couch and a computer desk. On the wall, in the common room, was posted a daily schedule which indicated that bedtime and lights out were at 10:30PM. A list of rules was also posted in the common area which indicated that youth were not allowed to congregate in other resident rooms. Record review revealed a 9/1/08 incident report that indicated that four male youths had tattooed themselves with a homemade tattoo gun while under staff supervision. Two of the male youths that tattooed themselves the night of 9/1/08 were available for interview. Resident #2 stated he snuck unnoticed into bedroom #2 at about 10:00PM to 10:30PM because Employee #1 was at the computer with his back to him. Resident #2 reported that when Employee #2 was leaving for the night, she came into bedroom #2 and caught residents tattooing themselves with a handmade tattoo gun. Resident #2 was interviewed about bedtime hours. Resident #2 stated that bedtime was supposed to be at 10:00PM, but staff never enforced it. Resident #2 reported he was one of the four residents that had tattooed themselves. Resident #3 verified Resident #2's version of the incident, but he could not recall the identity of the staff person sitting at the computer desk. Resident #3 stated that he did not sneak into bedroom #2 from his bedroom, that he walked normally. Resident #3 reported, "Maybe they did not think we were doing anything wrong, so they let us go into the bedroom." Resident #3 also	D 075		

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D 075	Continued From page 2	D 075		

stated that bedtime was at 10:00PM. Resident #3 further reported he was one of the four residents that had tattooed themselves.

Employee #3, the director, was interviewed about the 9/1/08 tattooing incident. The director stated that Resident #1 built a handmade tattoo gun and tattooed himself and three other youth (Resident #2, #3 and #4). The director further stated that after Employee #1 conducted a bed check, Employee #2 saw a light on in bedroom #2 and discovered seven residents in the room past bedtime. The director reported that bedtime was supposed to be at 10:00PM, but the incident happened at 11:15PM. The director also reported that Employee #1 was disciplined regarding his lack of supervision over the incident.

Employee #2, a swing shift staff person, reported that on 9/1/08 at 11:15PM to 11:20PM she was doing paperwork at the computer desk in the common room prior to leaving for the night when she noticed a light on in bedroom #2. Employee #2 asked Employee #1 to go into bedroom #2 to get all the residents out because it was past their bedtime and bedtime was supposed to be at 10:00PM. Employee #2 stated that Employee #1 went into the bedroom for a few minutes and then came out and sat on the couch in the common room. Employee #2 reported she wanted to give the residents a few minutes to "wrap it up," but noticed the bedroom light was still on. When she went to investigate, Employee #2 stated she found seven youth huddled around Resident #1 who said he was drawing. Employee #2 reported she saw the tattoo gun, took the gun and supplies and called her direct supervisor. When asked why seven youth were still up at 11:15PM, Employee #2 reported that Employee #1 let the

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D 075	Continued From page 3 residents make their own bed time decisions. Employee #1, a night shift staff person, reported that he normally arrived for his shift at 10:15PM to 10:30PM each night. When he showed up on 9/1/08, Employee #1 could not remember if the youth were in bed or not. Employee #1 stated that when Employee #2 went into bedroom #2 and discovered the youth tattooing themselves, he could not recall if he went in first. Employee #1 reported that if he had seen them tattooing themselves, he would have stopped it. Employee #1 further reported he believed there were four or five residents in bedroom #2; not seven. Record review revealed an employee discussion report dated 9/1/08 that indicated that Employee #1 had been written up for allowing teen youth to stay up past bedtime and allowing the youth to tattoo themselves. The report further indicated that any further concerns of lack of supervision would result in termination. With two staff persons in a building that lacked bedroom doors, four teen youths were able to tattoo themselves with a homemade tattoo gun. Severity: 3 Scope: 2	D 075		